



SURGERY PATIENT MEDICAL HISTORY INFORMATION, 1/2

Patient Information

M F Marital Status _____ Birthdate _____ Referred By _____
 Last Name _____ First Name _____ Middle _____ SS# _____
 Address _____ Apt # _____ City _____ State _____ Zip _____
 Home # _____ Work # _____ Cell # _____ Preferred # to Call _____
 Physician Name for Diabetic Care (if applicable) _____ Phone # _____
 Family Physician Name _____ Phone # _____

To avoid duplication, on the day of testing bring: any recent lab reports, chest X-ray report from a radiologist, and/or ECG tracings with an internist or cardiologist report. Any questions, call 248 471-8881.

A. Have you ever had any of the following:

	Yes	No	Doctor's Name / Where	Year
An Exam by a Cardiologist (Heart Doctor)				
Heart Catheterization				
Exercise Stress Test				
Ultrasound of Heart (Echocardiogram)				
Pacemaker				

B. To your knowledge, do you now have or have you ever had any of the following:

	Yes	No		Yes	No		Yes	No
Any Loose or Chipped Teeth Now			Mitral Valve Prolapse			Epilepsy/Seizures		
Caps/Bridges/Dentures/Bonding Root Canal/Crowns			Do you take Predental Antibiotics			History of Anemia (Low Blood Count)		
Temporal Mandibular Joint Dis.			Chronic Heartburn			Sickle-Cell Anemia/Trait		
Recent Cold, Bronchitis or Pneumonia			Hiatal Hernia			History of Bleeding or Bruising		
History of Asthma or Wheezing			Stomach Ulcer			Excess Bleeding from Surgery		
Tuberculosis or Silicosis			Kidney Disorder			Blood Trans		
Sleep Apnea			Thyroid Disorder			If there is a need for blood products during surgery is your surgeon aware of your personal preference?		
Shortness of Breath at Rest or with Limited Exercise			Diabetes			Are you a Jehovah's Witness		
Chronic Cough or Lung Problems			Liver Disease, Jaundice, Hepatitis			If Yes, Is Your Surgeon Aware		
High Blood Pressure			Stroke/TIA			Phlebitis/Blood Clots		
Chest Discomfort or Tightness with Exercise, Angina			Weaknesses or Paralysis			Problems with Poor Circulation to Feet/Legs		
Irregular Heart Beat, Palpitations			Multiple Sclerosis or Polio			Skin Problems		
Heart Attack			Head Injury			Hearing Problems		
Heart Failure			Chronic Back Problems			Vision Problems		
Rheumatic Fever			Scoliosis (Curvature of Spine)			Do you use any of the following: Cane, Walker, Crutches, Wheelchair		

C. Do you have any special concerns? _____

D.

- 1. Do you or have you ever smoked (including pipe/cigars)? Yes No
 Number of packs/cigars per day ____ Number of years ____ When was your last cigarette, cigar, pipe? _____
- 2. Do you drink alcoholic beverages on a weekly basis? Yes No
 If yes, how much do you typically drink in one week? _____
- 3. Are you Pregnant? Yes No Not Applicable Not Sure
 Date of last menstrual period _____
 (On the morning of surgery, please advise your anesthesiologist if there is any possibility you may be pregnant.)

E. Please List All Medications you are presently taking, including dosage and frequency. Please include non-prescription medications, such as iron, aspirin, antacid, laxatives, including any aspirin like products.

F. Please List Allergies and the reaction they cause, including foods:

Have you or any blood relatives had problems with anesthesia? Yes No

If yes, describe: _____

F. Please List all previous hospitalizations (surgery, childbirth, medical illness):

Date (Approximate Year)	Reason	Place (Hospital or City)

F. Have you ever been a patient at RTH? Yes No Last Date _____

Signature of Patient, Parent or Legal Guardian

Today's Date

Date	Height	Weight	BP	P	Res	Temp
------	--------	--------	----	---	-----	------

Pat R.N. _____